CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR PHARMACIST LICENSURE BY EXAMINATION OR SCORE TRANSFER
INSTRUCTION SHEET

When to File Application by Examination or Score Transfer

How you apply for a Pharmacist license depends on whether you have passed the North American Pharmacist Licensure Examination (NAPLEX) and, if so, when you passed it, whether you requested a score transfer to Delaware and whether you are already licensed in another jurisdiction (state, U.S. territory or District of Columbia).

If either of the following situations applies to you, you must apply by License Transfer (Reciprocity).

- You passed the NAPLEX *less* than one year ago but you did ***not*** designate Delaware as a score transfer state.
- You passed the NAPLEX *over* one year ago and you are *currently* licensed in another jurisdiction.

If neither of the situations above applies to you, file the *Application for Pharmacist Licensure by Examination or Score Transfer* form. The first question on the form asks you to select whether you are applying by Examination or Score Transfer. Use this table to decide which to check.

IF you…	**AND IF** you…	**THEN** check…
have *not* passed the NAPLEX	want Delaware to be your primary jurisdiction for eligibility	Examination
	have applied to take it in another jurisdiction and requested (or will request) score transfer to Delaware	Score Transfer
passed the NAPLEX *over* one year ago	are ***not*** *currently* licensed in another jurisdiction	Examination
passed the NAPLEX *less* than one year ago	requested score transfer to Delaware when you took it	Score Transfer

Internship Requirement

Whether applying by Examination or Score Transfer, you must complete 1,500 hours of Board-approved pre-licensure experience before you can be considered for licensure. If you have not completed all 1,500 hours when you file this application and you wish to attain any remaining hours while working in Delaware, you must file an *Application for Registration for Internship* ***in addition to*** this application. The Board office will issue you a permit to allow you to work as a Pharmacist Intern in a Delaware Pharmacy.

Requirements for *All* Applications

The following are required for all applications, regardless of whether you are applying by Examination or Score Transfer.

☐ Submit completed, signed and notarized *Application for Pharmacist Licensure by Examination or Score Transfer*.

☐ Enclose non-refundable processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for Board office to receive a State of Delaware and Federal Bureau of Investigation criminal background check following the instructions on the *Instructions for Requesting a Criminal Background Check* form included with this application.

- **It is strongly suggested that you submit your request to the State Bureau of Identification promptly** because it may take up to eight weeks for the Board office to receive the criminal background check.

☐ Submit proof of your pharmacy education:
- If you graduated from a school or college of Pharmacy in the U.S., submit a *Certificate of Graduation Form* completed by your school or college of Pharmacy and sent directly to the Board office.
- If you graduated from a school or college of Pharmacy outside the U.S., submit a copy of your Foreign Pharmacy Graduate Examination Committee (FPGEC) Certificate. For an application, go to www.nabp.pharmacy.

Note: If you have not yet graduated from a school or college of Pharmacy, see the **Registering to Take the Examination** section below.

☐ Arrange for the Board office to receive proof that you have completed 1,500 hours of Board-approved internship. Proof consists of any of these that apply:
- *College Practical Experience Form* completed by your school or college of Pharmacy for practicum hours and sent *directly* to the Board office
- *Affidavit of Intern Experience* form(s) to document any pre-licensure or internship hours you have worked in a pharmacy, completed by your preceptor and sent *directly* to the Board office.
- Transfer of internship hours from another jurisdiction(s), sent *directly* from each jurisdiction's Board of Pharmacy to the Delaware Board office

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Registering to Take the Examination

In addition to filing this application, you must register with NABP to take the Multi-State Pharmacy Jurisprudence Examination (MPJE) and, if you have not already passed it, the NAPLEX. To register, go to: www.nabp.pharmacy. ***You should register with NABP at the same time you file this application.*** Until you register with NABP, the Board office cannot make you eligible to take the exam.

The Board office will determine if you are eligible to take the examination when it has received all of the following:
- Application
- Processing fee
- *Request for Exemption from Social Security Number Requirement*, when applicable
- Proof of your education as follows:
  - If you have graduated, the Board must receive either the *Certificate of Graduation* or FPGEC, whichever applies.
  - If you have not yet graduated, arrange for the Board office to receive an official letter from your school or college of Pharmacy stating that you have met all requirements for graduation. The letter must be sent directly from the school or college to the Board office. This letter is sufficient only to allow you to take the examination; it is *not* sufficient proof of education for licensure.

When the Board office makes you eligible, NABP will send you an *Authorization to Test* letter that will explain how to schedule your examination.

For help on preparing for the MPJE, click MPJE Study Material List.

NABP will notify you of the results. If you pass, ***all*** items listed in the **Requirements for *All* Applications** section above will be required before your Pharmacist license is issued.

Re-Taking an Examination

If you do not pass an exam, you must wait before you can re-take the exam as follows:
- 91 days after failing the NAPLEX
- 31 days after failing the MPJE

To re-take an exam, you must re-register on www.nabp.pharmacy, and the Board office must re-confirm your eligibility. For more information about re-taking the exams, see Section 1.2 of the Board's Rules and Regulations.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR PHARMACIST LICENSURE BY EXAMINATION OR SCORE TRANSFER

TYPE OF APPLICATION

1. Select the item that describes your situation:

☐ I am applying for Pharmacist licensure by *Examination*. Check one:
- ☐ I have ***not*** yet passed the NAPLEX and I want Delaware to be my primary state for eligibility.
- ☐ I need to re-take the NAPLEX. I previously passed it over a year ago but I am ***not*** *currently* licensed in another jurisdiction.

Register to take the NAPLEX with the National Association of Boards of Pharmacy at www.nabp.pharmacy.

☐ I am applying for Pharmacist licensure by *Score Transfer*. Check one:
- ☐ I have *already passed* the NAPLEX *and* I requested score transfer to Delaware when I took the NAPLEX.
- ☐ I have *applied to take* the NAPLEX in another jurisdiction *and* have requested (or will request) score transfer to Delaware.

If *none* of the situations above applies to you, you must apply by License Transfer (Reciprocity).

IDENTIFYING AND CONTACT INFORMATION

2. Full Name: _____ (Last) _____ (First) _____ (Middle)

3. Other Names Used: _____ _____ _____
(Include maiden, prior married, alternate spellings)

4. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

5. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:**_____
If no, you must file a *Request for Exemption from Social Security Number Requirement*.

6. Mailing Address: _____

_____ (City) _____ (State) _____ (Zip)

7. Phone: _____ (Home) _____ (Work) Email: _____

EDUCATION INFORMATION

8. Name of Pharmacy School or College: _____

9. Have you graduated? Yes ☐ No ☐ If no, arrange for the Board office to receive an official letter from your school or college of Pharmacy, sent directly from the school/college to the Board office, stating that you have met all graduation requirements.

When you have graduated, proof of education is required as follows. If your college/school of Pharmacy is:
- ***outside* the U.S., submit your FPGEC Certification.**
- ***in* the U.S., arrange for your school/college to submit the *Certificate of Graduation in Pharmacy* form.**

INTERNSHIP INFORMATION

10. Have you completed 1,500 internship hours? Yes ☐ No ☐
    - If yes, arrange for the Board office to receive any of these that apply:
      - o ***College Practical Experience Form***
      - o ***Affidavit of Intern Experience***
      - o **verification of intern hours from other jurisdiction(s)**
    - If no, you must successfully complete the hours *before* you will be considered for Delaware Pharmacist licensure. If you wish to attain any internship hours in Delaware, **complete and submit an *Application for Registration for Internship* *in addition to* this application.**

11. Have you been registered as an intern in any jurisdiction(s), including Delaware? Yes ☐ No ☐ If yes, the following information about *each* jurisdiction where you have been registered as a Pharmacy intern:

JURISDICTION	INTERN REGISTRATION NUMBER	ISSUE DATE

DISCLOSURES

12. Have you ever received an administrative penalty (discipline) regarding your practice of pharmacy, including but not limited to fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a consent agreement containing conditions placed by a Board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a complete explanation and provide documentation of the regulatory Board action.**

13. Are you aware of any disciplinary proceedings or unresolved complaints pending against you in any jurisdiction where you have previously been or are currently licensed or registered? Yes ☐ No ☐ **If yes, enclose a complete explanation and provide documentation of the regulatory Board action.**

14. Do you have any impairment related to drugs, alcohol, or mental competence that would limit your ability to act as a pharmacist in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a complete explanation.**

DUTY TO REPORT

15. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

16. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

17. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when
    - your license to practice pharmacy has been disciplined, surrendered, suspended or revoked, or
    - you have been convicted of a crime that is substantially related to the practice of pharmacy.

    I certify that I have read and understand 24 *Del. C.* §2515 (a)(8) and that I understand my *duty to self report*. Yes ☐ No ☐

If your application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I do hereby make application to the Board of Pharmacy for license or registration under the provisions of an Act to regulate the practice of Pharmacy in the State of Delaware and solemnly swear and affirm that the answers to the questions set forth in this application are true and correct.

Signature of Applicant: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

CERTIFICATE OF GRADUATION IN PHARMACY

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who graduated from a school or college of Pharmacy in the U.S.

- The applicant completes the **APPLICANT INFORMATION** section and sends this form to his or her school or college of pharmacy.
- The Dean or Secretary of the college or school completes the information in the **CERTIFICATION** section, signs and seals the form and sends it directly to the Board office at the address above.

APPLICANT INFORMATION

Applicant Name: _____

CERTIFICATION

1. Name of Pharmacy School or College: _____
2. Degree Awarded: _____
3. Degree Date: _____

I certify that the above information is accurate.

Printed Name of Secretary or Dean: _____

Signature of Secretary or Dean: _____ Date: _____

AFFIX
INSTITUTION
SEAL

Send this form *directly* to the Board of Pharmacy office at the address above.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 9/2017

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLA

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

COLLEGE PRACTICAL EXPERIENCE FORM

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who completed internship hours while in a school or college of Pharmacy.

- **The applicant completes the APPLICANT INFORMATION section and sends this form to his or her school or college of pharmacy.**
- **An official of the college or school completes the information in the VERIFICATION section, signs and seals the form and sends it directly to the Board office at the address above.**

APPLICANT INFORMATION

Name of Applicant: _____

VERIFICATION

1. Name of School or College of Pharmacy: _____
2. Is/was the applicant named above a full-time student at this school or college of Pharmacy? Yes ☐ No ☐
3. Has the applicant successfully participated in the school's Practical Experience Program? Yes ☐ No ☐
4. Enter the number of hours of practical experience that the applicant obtained ***during or after the first professional year*** of the Pharmacy curriculum.

   Total Hours: _____ From (month/day/year): _____ To (month/day/year): _____
5. Enter the minimum number of hours of experience that the ***current*** structure of the Practical Experience Program at this institution requires:

   Community Pharmacy Practice: _____ hours

   Hospital Pharmacy Practice: _____ hours

   Clinical Pharmacy Services: _____ hours

"Clinical Pharmacy Services" include medical rounding, patient chart review, drug therapy assessment, patient interview and education.

I certify that the above information is accurate.

School Official's Printed Name: _____ Title: _____

Signature Of School Official: _____ Date: _____

AFFIX
INSTITUTION
SEAL

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 9/2017

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AFFIDAVIT OF INTERN EXPERIENCE

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who completed internship hours while employed in a pharmacy business.

- **The applicant completes the APPLICANT INFORMATION section and sends this form to his or her supervising pharmacist.**
- **The supervising pharmacist completes the remainder of the form, signs it in the presence of a notary and sends it *directly* to the Board office at the address above.**

APPLICANT INFORMATION

Name of Applicant: _____

INFORMATION ABOUT SUPERVISING PHARMACIST

1. Name of Supervising Pharmacist: _____
2. Delaware Pharmacist License Number: **A1 -** _____
3. Pharmacy Where Employed: _____
4. Pharmacy Address: _____

   _____ _____ _____
   City State Zip
5. Delaware Pharmacy License Number: **A**___ - _____
6. Did you supervise the applicant above while he or she obtained professionally-oriented experience in the practice of pharmacy at the pharmacy entered above? Yes ☐ No ☐
7. Enter the following information about the hours of experience the applicant obtained under your supervision. ***If the applicant is a foreign pharmacy graduate, the hours entered must be after the date of FPGEC certification.***

START DATE	END DATE	HOURS
	TOTAL HOURS	

EVALUATION

8. The purpose of this evaluation is to alert the intern to weaknesses or any problem areas. Assess the applicant's professional development as demonstrated at the end of the experience period under your supervision. Using the Performance Criteria below, enter a grade for each of the nine areas of pharmacy practice. If any of these questions does not apply, refer to *Intern Performance Evaluation Comment Sheet*.

PERFORMANCE CRITERIA

A–Intern is able to perform this activity very effectively without supervision. Intern is fully prepared to assume this responsibility in practice.
B–Intern requires only occasional supervision to perform this activity effectively.
C–Intern is slow and/or requires frequent supervision to perform this activity. Intern needs additional experience to assume this responsibility in practice.
D–Intern makes significant mistakes on a regular basis, but may demonstrate an understanding of the concepts.
E–Intern is either unable to perform or insufficiently prepared to perform this activity.

1. Ability to apply knowledge of state and federal pharmacy law in the dispensing of medications:
   ☐ A ☐ B ☐ C ☐ D ☐ E
2. Ability to apply knowledge of Pharmacy Law in the acquisition (DEA order form) and distribution of controlled substances:
   ☐ A ☐ B ☐ C ☐ D ☐ E
3. Ability to dispense medications from prescription orders, including order interpretation, product selection, labeling and packaging:
   ☐ A ☐ B ☐ C ☐ D ☐ E
4. Ability to dispense (sterile & non-sterile) dosage forms requiring extemporaneous or bulk compounding:
   ☐ A ☐ B ☐ C ☐ D ☐ E
5. Ability to obtain and utilize patient-related information (i.e. patient profiles, interview, etc.) to insure patient safety and to minimize significant drug interactions and therapeutic incompatibilities:
   ☐ A ☐ B ☐ C ☐ D ☐ E
6. Ability to effectively consult with patients about their prescription drug therapy:
   ☐ A ☐ B ☐ C ☐ D ☐ E
7. Ability to perform basic triage functions with patients and to select and counsel patients on appropriate over-the-counter drugs or to refer patients to other health care providers (optional for Hospital Pharmacy Experience Externs/Interns):
   ☐ A ☐ B ☐ C ☐ D ☐ E
8. Ability to maintain pharmacy records, including DEA records, prescription files, patient profiles and counseling records:
   ☐ A ☐ B ☐ C ☐ D ☐ E
9. Ability to communicate with other health care professionals about patient therapy and/or drug information:
   ☐ A ☐ B ☐ C ☐ D ☐ E

AFFIDAVIT

I certify that I am a registered pharmacist in good standing, that I personally supervised the applicant above and I have accurately entered the applicant's professional assessment and recorded hours, to the best of my ability.

Signature of Supervising Pharmacist: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

INTERN PERFORMANCE EVALUATION COMMENT SHEET

INSTRUCTIONS

This form is for applicants for Delaware Pharmacist licensure who completed internship hours while employed in a pharmacy business. If evaluation of any performance statement in the EVALUATION section on the *Affidavit of Intern Experience* does not apply, the intern's supervising pharmacist completes this comment sheet to explain. For example, use this form to give an evaluation of the Intern's performance pertaining to experience in an alternate field of practice. The supervising pharmacist signs the form in the presence of a notary and sends it *directly* to the Board office at the address above.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Supervising Pharmacist: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.

Revised 9/2017